STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 00 B. WING	05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 W STATE RD 46 ELLETTSVILLE, IN47429

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F0000	This visit was for the investigation of Complaint IN00089976 and IN00088776. Complaint IN00088776- Substantiated, Federal/state deficiencies related to the allegations are cited at 323. Complaint IN00089976-Substantiated, no deficiencies related to allegations are cited. Survey date: May 5, 2011 Facility number: 000558 Provider number: 155523 AIM number: 100267550 Survey Team: Marla Potts RN, TC Melinda Lewis RN Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 11 Medicaid: 36 Other: 27 Total: 74	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 4 This deficiency also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 5-9-11 Cathy Emswiller RN			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure residents at risk of falls were provided with supervision to prevent falls, in that Resident G's alarm did not ring when she stood from the bed, resulting in a fall and hip fracture, Resident W had repeated falls without an increase in supervision, resulting in a fall with aleft fhumeral head (shoulder) fracture, for 2 of 3 residents reviewed for falls in the sample of 4. Resident G and W	F0323	F 323:Richland Beam Blossom health Care has policies and procedures in place to assist in ensuring that residents have an environment that remains as free from accident hazards as is possible and that each resident receives adequate supervision and/or assistive devices to aide in the prevention of accidents.**Corrective action for those residents who have been allegedly found to be affected:** 1. Resident G, has been free from falls since 3/31/11. On 3/31/11 all fall prevention interventions were in place in	05/17/2011

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	Findings include 1. The clinical record for Resident G was reviewed on 5/5/11 at 9:45 A.M. The record indicated Resident G had diagnoses that included but were not limited to history of left hip fracture, severe diffuse osteopenia and senile osteoporosis. The MDS [minimum data set] assessment, dated 1/3/11, indicated Resident G had severe cognitive impairement. Resident G required extensive assistance of one with bed mobility and extensive assistance of two with transfers and toilet use. Resident G had no falls since the prior assessment. A care plan, dated 6/22/10, reviewed 3/31/11 and 4/6/11, 4/7/11, indicated a problem of "I am at risk for falls r/t [related to] poor safety awareness. I have been known to roll or climb out of bed and crawl on the floor. I have osteopenia, osteoarthritis and osteoporosis." The interventions were "I have a fall risk assessment, upon admission, quarterly and PRN [as needed] thereafter. I have assist of 2 for transfers with hoyer (lift) from surface to surface. Pharmacy may review my medications that increase potential for falls. I have a bed and chair alarm in place. I have been instructed to call for help if I need assitance. I have a high-low bed. I have a mat on the floor.		accordance with the residents' plan of care and as stated on the nurse aide assignment sheets. It is noted as per the facility investigation that the residents alarm was functioning during a bed check just 15 minutes before the resident was noted lying on her fall mat and upon the charge nurse testing the alarm directly after resident being found on the fall mat. Hourly checks documented are present dating back to 4/19/10. Also it is identified per physician review and progress note that the resident upon arising from her bed to get a drink, endured a pathological fracture to her L leg which led to a fall. A spontaneous fracture could have occurred when turning in bed leading to the fall when the resident was on the side of the bed reaching for the water glass. Resident was given a bed alarm with a larger perimeter pad on 3/31/11, care plan was update as to this intervention. On 5/5/11 a new fall risk assessment was preformed; interventions, Care Plan and nurse aide assignment sheets were reviewed and no further updates were found to be necessary. 2. Resident W, has been free from falls since 4/23/11. The residents' medical record shows that staff were responding to his needs and following Care plan interventions appropriately. Resident's personal safety alarm is responded to by staff and	

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	1-21-11 I have a perimeter mattress." The Fall Risk Assessment, dated 1/3/11, indicated a score of 11. The form indicated "Total Score above 10 represents HIGH RISK." The Nurses Notes, dated 3/8/11 at 12:45 A.M., indicated "Alarm sounded CNA ran to residents room and found her laying on Rt [right] side on her mat next to bed. When ask what she was doing stated I don't know...Able to move all extremities normal for herself. Hematoma (raised) over Rt brow area. Neuro checks started..." The Nurses Notes, dated 3/8/11 at 1:00 A.M., indicated "Returned to bed for further assessment. No c/o [complaints of] discomfort voiced..." The Nurses Notes, dated 3/8/11 at 3:00 A.M., indicated "...Intervention of placing foam over bed frame added to care plan. DON [Director of Nursing] aware of intervention." The 6/20/10 fall care plan was updated on 3/8/11 to include the intervention of "My bed frame is covered with foam." The Nurses Notes, dated 3/31/11 at 12:45 A.M., indicated "Writer called to res		assistance and intervention provided. Resident was and continues to be checked every 2 hours for offered toileting needs, offered food or fluids, asking resident if he was having pain and offering medication if desired and indicated, and changing residents atmosphere as desired by bringing him up to nurse station for social conversation. Residents' room was moved closer to the nurse's station for closer supervision access on 4/23/11. On 5/6/11 new fall risk assessment was preformed; interventions , Care Plan and nurse aide sheets were reviewed and no further updates were found to be necessary**Identifying others having the potential to be affected:** New Fall Risk assessments have been completed on all residents. Any residents deemed having the potential to be affected were Care Planned; interventions put in place and nurse aide assignment sheets updated.**Systemic changes put into to place:** The Nursing staff was re-in serviced regarding fall prevention and intervention protocol 5/5/11 thru 5/13/11.Fall risk assessments will be completed on admission, quarterly and with any significant change and the residents individualized care plan will be reviewed and the care plan and nurse aide assignment sheets will be checked for accuracy and updated as deemed necessary.	

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	[resident] rm [room] by CNA. Res laying on R [right] side on blue mat. Res holding L [left] thigh area with bil [bilateral] hands. Writer noted L upper leg to be visibly out of proper alignment with inner rotation noted. No visible s/s [signs or symptoms] trauma to L left noted...Res moving L leg staff propped L leg with pillows et [and] staff member holding leg in proper alignment...Res alert et [and] confused as per res usual. Res c/o[complained of] mod [moderate] pain to L leg. No further injuries. Writer asked res what she was doing res states I was trying to get something to drink. Writer noted res water cup et juice cup tipped over et spilled on top of bedside cabinet. Writer explained to res that she will remain on blue mat with L leg being stabilized by staff pending transport to ER [emergency room]..." The facility lacked evidence to indicate the alarm was intact and functioning at the time of the fall. The Nurses Notes, dated 3/31/11 at 5:30 A.M., indicated "(Name) Hosp [hospital] called to report L femur fx [fracture] just below old hip fx. Will splint and place in traction..." In an interview with the Director of Nursing, on 5/5/11 at 12:25 P.M., she indicated Resident G had been on hourly checks for about a year. She indicated it		The Director of Nursing and/or the Assistant Director of Nursing will be responsible for assuring the fall assessments are completed timely. The Interdisciplinary Team will review new fall events during the morning management meetings five (5) times weekly. The Interdisciplinary Team review will include review of residents' plan of care, fall interventions and incident investigation findings. Fall prevention interventions will be reviewed monthly through person at risk (PAR) meetings to assure interventions are applicable, affective and to ascertain new opportunities for improvement.**Monitoring of Corrective Actions:** Fall events and preventative interventions will be monitored by the Interdisciplinary Team weekly in persons at risk (PAR) meetingsThe Director of Nursing and/or designee will monitor fall assessments weekly to assure fall assessments are completed timely upon admission, quarterly and with a significant change in condition. The Director of Nursing or designee will perform documented Fall Management Rounds 3 times weekly, results will be discussed with nursing staff and as applicable corrections will be immediate and appropriate interventions as applicable with any issues reported to the Administrator.The Quality Assurance Committee will	

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	was not documented to check Resident G hourly in the record, the staff just knew to do it. In an interview with the Director of Nursing and Administrator, on 5/5/11 at 1:30 P.M., they indicated Resident G's bed alarm did not sound prior to the fall on 3/31/11. 2. The clinical record for Resident W was reviewed on 5/5/11 at 10:45 A.M. The record indicated Resident W had diagnoses that included, but were not limited to, dementia and renal cell cancer. The MDS [minimum data set] assessment, dated 4/11/11, indicated Resident W had severe cognitive impairment. Resident W required limited assistance of one with bed mobility and transfers, and extensive assistance of one with ambulation and toilet use. The MDS indicated Resident W had fallen since admission to the facility. The resident was documented to have entered the facility on 4/4/11. A fall risk assessment, dated 4/4/11, indicated a score of 11. The form indicated "Total score above 10 represents HIGH RISK." The Nurses Notes, dated 4/5/11 at 3:50 A.M., indicated "Alarm sounded in		meet and review audit forms monthly. Fall tracking and trending results will be discussed and new monitoring measures will be put into place as deemed necessary.	

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	Resident's room upon entering his room this nurse saw res sitting on the side of his bed attempted to get up et [and] slid down from bed to floor. This nurse ran et[and] helped res down to dry floor. No injuries noted upon assessment...Blue mat next to bed. Res requested to get out of his room. Res was helped to his chair and is in nurses station with staff member keeping him company. Alarm is in place et activated..." A fall risk assessment, dated 4/9/11, indicated a score of 11. The form indicated "Total score above 10 represents HIGH RISK." A Care plan, dated 4/13/11, indicated a problem of "I am at risk for falls due to my medications and lack of safety awareness." The interventions were "I have a fall risk assessment upon admission, quarterly and PRN [as needed] thereafter. I am assist with ADLs [activities of daily living] and transfers. Staff uses a gait belt to enhance safety during transfers. Please keep walkways and paths free from clutter and obstructions. Please offer frequent rest periods during care and activities to lessen fatigue. Pharmacy may review my medications which may increase potential for falls. I have been instructed to call for help if I need assistance. I have a bed and			

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	chair alarm to alert staff when I am attempting to transfer myself." A fall risk assessment, dated 4/14/11, indicated a score of 12. The form indicated "Total score above 10 represents HIGH RISK." The Nurses Notes, dated 4/21/11 at 5:30 A.M., indicated "Alarm sounding, CNA entered rm [room] Resident was sitting on toilet then raising up stubbed toe on floor and fell to right side. Summoned nurse. This nurse entered rm. Active ROM [range of motion] done to all extremities. No bruising noted but c/o [complains of] R [right] side hurting when assisted up...Resident assisted back to bed x [times] 1. Resident was assisted off floor x 2." The Nurses Notes, dated 4/21/11 at 6:50 A.M., indicated "New interventions: Empty cath [catheter] bag Q [every] 4 hours (minimum); toileting when awake, mat on floor by bed, CXR [chest x-ray]..." The fall care plan, dated 4/13/11, was updated on 4/21/11 to include the intervention of "Take to BR Q 2 hours when awake. Floor mat." The Nurses Notes, dated 4/22/11 at 11:30 P.M., indicated "C/T [continues to] toilet			

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	res Q [every] 2 has sounded bed alarm x 1 staff immediately entered room res standing beside bed. Staff assisted to BR [bath room] then back to bed res states I'm tired." The Nurses Notes, dated 4/23/11 at 12:30 A.M., indicated "res sounded bed alarm res standing unassisted by bed staff assisted to BR redirected use of call light states understanding but C/T [continues to] not utilize call light. Confused denies c/o's pain. Medicated with routine Tylenol at this time, fluids offered et accepted." The Nurses Notes, dated 4/23/11 at 3:15 A.M., indicated "Bed alarm sounding this nurse entered res room et observed res lying on floor mat beside bed on stomach states I fell going to the bathroom...c/o's L [left] shoulder pain. Decreased ROM et unable to raise L arm up. ii [two] person assist to stand per waist et assisted to bed slight swelling noted at L shoulder..." The Nurses Notes, dated 4/23/11 at 3:30 A.M., indicated "Notified Dr (name) with new order received to send to (name) ED [emergency department] via ambulance to eval [evaluate] et tx [treat] L shoulder pain." The Emergency Department Chart, dated 4/23/11, indicated "...X ray of the left			

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	humeral head shows an acute fracture..." The 4/13/11 fall care plan was updated on 4/23/11 to include the intervention of "I have 1/2 hour checks." The 4/13/11 fall care plan was updated on 4/27/11 to include the intervention of "My room has been moved closer to nurses station." This federal tag relates to complaint IN00088776. 3.1-45(a)(2)			

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